

John Webber, M.D.

07/29/2025

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

KOHCHISE JACKSON,

Plaintiff,

Case No. 19-cv-13382

-vs-

Hon. Gershwin A. Drain

CHS TX, INC., et al.,

Defendants.

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The de bene esse video deposition of

JOHN WEBBER, M.D.,

Taken at 1 William Carls Drive, Conference Room 1C,

Commerce Charter Township, Michigan,

Commencing at 4:40 p.m.,

Tuesday, July 29, 2025,

Before Jennifer Wilke, CSR-8575.

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18 THE VIDEOGRAPHER: Marc Myers
 19
 20 ALSO PRESENT: Ian Cross, Esq.
 21 Neal Rogers
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1 Commerce Charter Township, Michigan
 2 July 29, 2025
 3 About 4:40 p.m.
 4 THE VIDEOGRAPHER: We are now on the record.
 5 This is the video-recorded deposition of Dr. John Webber
 6 being taken in Commerce Township, Michigan. Today's
 7 date is July 29th, 2025. The time is now 4:40 p.m.
 8 And at this time, will the attorneys please
 9 state their appearances for the record, and the court
 10 reporter, please swear in the doctor.
 11 MR. MARKO: Good afternoon, ladies and
 12 gentlemen of the jury, Judge Drain. This is Jon Marko
 13 on behalf of the plaintiff, Kohchise Jackson.
 14 MS. WEIL: Good afternoon. This is
 15 Rachel Weil from Bowman & Brooke on behalf of the
 16 defendants CHX Texas and Dr. Keith Papendick.
 17 THE COURT REPORTER: And, Dr. Webber, please
 18 raise your right hand. Do you solemnly swear or affirm
 19 that the testimony you are about to give will be the
 20 truth, the whole truth, and nothing but the truth?
 21 DR. WEBBER: Yes, I do.
 22 JOHN WEBBER, M.D.,
 23 having first been duly sworn, was examined and testified
 24 on his oath as follows:
 25 MR. MARKO: Good afternoon, Doctor.

1 THE WITNESS: Good afternoon, Mr. Marko.
 2 VOIR DIRE EXAMINATION BY MR. MARKO:
 3 Q. I'm Jon Marko. I met you today for the first time; is
 4 that true?
 5 A. That is true.
 6 Q. And tell the jury who you are.
 7 A. I'm John Webber, and I am a general surgeon --
 8 board-certified general surgeon.
 9 Q. And just so we can orient ourself as to how you came in
 10 to be a character in this case --
 11 A. Yes.
 12 Q. -- you are the doctor that performed the colostomy
 13 reversal on my client, Mr. Jackson?
 14 A. I am.
 15 Q. And so if we look at -- this is a demonstrative timeline
 16 that the jury will have seen by now, but assuming
 17 Mr. Jackson was released on May 16th, 2019, you
 18 performed the surgery on June 19th, 2019, to reverse the
 19 colostomy that he had?
 20 A. Yes. If that is what the record states, yes.
 21 Q. Okay. And are you some doctor that anybody went out and
 22 found to pay to be in this case, or are you a treating
 23 doctor?
 24 A. So, I am a treating doctor. And I was offered paid in
 25 this case, but I have not accepted payment for this

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1 case.

2 Q. You're testifying without payment even though you know
3 you're entitled to it for your time as a medical
4 professional?

5 A. That's correct. I am not.

6 Q. Why, Doctor?

7 A. Well, one, because I think in this case, my morals
8 wouldn't allow me to be paid for it because I'm a
9 treating physician here and I am going to speak my
10 opinion about what I believe should or should not have
11 been done.

12 Q. Thank you so much on behalf of Mr. Jackson, Doctor.

13 A. All right.

14 Q. I appreciate your time, and I will try to respect it as
15 much as I can and move this along, okay?

16 A. Thank you, sir.

17 Q. So, we're gonna give the jury a little road map here.
18 So, we're gonna talk about your credentials, your
19 background, and then we're gonna talk about how you
20 began -- you became to treat as a treating physician to
21 try to heal Kohchise Jackson, then we're gonna talk
22 about some of your opinions in this case. Does that
23 sound fair?

24 A. Yes.

25 Q. So, let's just get the million doctor question out of

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1 the way here. Dr. Webber, in your professional medical
2 opinion, as a treating physician, a neutral treating
3 physician, was Mr. Jackson's reversal surgery that you
4 performed on June 19th of 2019 medically necessary?

5 A. Yes. Without a doubt.

6 Q. Without a doubt, you say?

7 A. Yes.

8 Q. One other area that we're gonna cover today: Was a
9 delay in Mr. Jackson's reversal surgery of at least two
10 years to get this colostomy reversed, did it pose
11 medical harm risks to Mr. Jackson to have it delayed
12 that long?

13 A. So, yes. There are different types of harm that could
14 occur from failure or delay in reversal. If you broadly
15 categorize the harm into psychological harm versus
16 physical or physiologic harm, two different categories.

17 Obviously, there's a psychological component
18 to wearing a colostomy bag for the patient. They're --
19 again, you know, people don't like them, that's not
20 natural, you're not born with a colostomy, and
21 therefore, patients see a psychological issue with it.
22 It usually lowers or devalues the patient's sense of
23 self-worth to some extent. They are afraid to, you
24 might say, interact socially with people because of how
25 they may be perceived by others who don't have a

1 colostomy bag; meaning, they don't look like all the
2 other people that they may be present with. If you go
3 to events like a pool party or something like that, they
4 would have difficulty interacting in that environment.

5 And, again, there's a lot of emotional toll
6 that it takes on a patient to have to wear a colostomy
7 bag for a prolonged period of time. And some of that
8 emotional damage is hard to recover, even after the
9 colostomy is reversed.

10 But speaking to the physical harm that
11 potentially could occur, colostomies are not without
12 complication, and colostomies are known to develop
13 complications in quite a few percentage of the patients.

14 Q. You're talking about the bag, the colostomy --

15 A. The actual colostomy itself.

16 Now, when you say bag, that's a physical
17 appliance that covers the actual colostomy. The
18 colostomy, we abbreviate in the medical field as a
19 stoma, S-T-O-M-A, and that literally means that the part
20 of the intestine where the rest of the colon, in that
21 case, it would be the colostomy, or the ileum, in that
22 case, it would be an ileostomy, the actual bowel is
23 brought out through the abdominal wall and sutured to
24 the skin so that the patient literally defecates onto
25 their skin.

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1 Obviously, we don't want them to defecate onto
2 their skin, but they -- that's why we pouch it with a
3 bag. So, the bag is technically just the appliance that
4 you place over the colostomy itself.

5 Q. Understood. And is that delay in getting reversal, is
6 there a risk of physical harm?

7 A. Yes. So, the physical harm that can occur when you
8 don't reverse a colostomy is they can develop what is
9 called prolapse of a colostomy, and that's where the
10 colostomy protrudes out for some distance from the skin
11 level. Typically, when we put them there, they're only
12 protruding maybe a couple centimeters above the level of
13 the skin.

14 Q. Understood.

15 A. But in a case of a prolapse, they can protrude to be
16 many centimeters, even 15, 20 centimeters.

17 Q. Understood.

18 A. And that could cause problems with the actual process of
19 defecation.

20 Another complication of a colostomy is the
21 development of what we would call a paracolostomy or a
22 parastomal hernia where the original hole that the colon
23 goes through, although, we try to make the hole in the
24 muscle layers or fascia snug around the colostomy, in
25 time, as it occurs in almost all patients, the hole

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1 widens. And then you get a bigger hole. The colon
2 itself or the colostomy remains the same size or
3 diameter, but the hole around it is now wider and so
4 knuckles of bowel can sneak into there and develop what
5 we call a bowel obstruction. And bowel obstructions can
6 and sometimes are life-threatening. I mean --

7 Q. So, these are all risks of harm that Mr. Jackson would
8 have been exposed to due to the prolonged delay in
9 getting the reversal?

10 A. Yes. And --

11 MS. WEIL: Objection. Argumentative.

12 Q. Go ahead.

13 A. And another complication of a colostomy is the
14 development of what we call a colostomy stenosis, or a
15 recessed colostomy, where the colostomy shrinks.
16 Instead of being rose budded off the abdominal wall by
17 two centimeters, it actually recesses into the skin so
18 that it's hard to even see. And if it becomes stenotic
19 or recessed or sunken, some people call it a sunken
20 colostomy, it's hard to defecate through that colostomy,
21 and that would mimic a large bowel obstruction which is
22 also life-threatening.

23 Q. These are serious risks?

24 A. Again --

25 MS. WEIL: Objection. Argumentative.

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1 Q. Are they serious risks?

2 A. Not only serious risks, but potentially life-threatening
3 risks.

4 Q. Understood. Let's talk about who you are and some of
5 your background so the jury knows how you're qualified
6 to give opinions in this case. Tell the jury, where
7 were you born, and tell us about your education.

8 A. Sure. I was born in Osaka, Japan, many, many years ago,
9 and I was actually put in an orphanage, my twin brother
10 and I. And thank God my adoptive parents, for better or
11 worse, couldn't have their own children so they -- my
12 dad was actually flying in Vietnam during the Vietnam
13 War for the U.S. military, and he decided, he -- my
14 mother -- I'm sorry. My mother and him decided to adopt
15 us, my twin brother and I.

16 So, we came to the United States in 1969, went
17 to U.S. schools, ended up living in Georgia -- it's
18 pertinent to the story -- and one day, I was watching TV
19 and watched the Wolverines play, and I loved the
20 helmets.

21 And I said to my dad, because he was flying in
22 Michigan for a company in Michigan now, and I said, "Who
23 are these guys with these helmets?"

24 And he goes, "Those are the Michigan
25 Wolverines." They go -- he goes, "I fly out of

1 Ypsilanti right by Ann Arbor."

2 And I had good grades, and I said, "I want to
3 go to that school."

4 So, I applied U of M after I toured it, flew
5 up with my dad and toured it, and went to University of
6 Michigan Ann Arbor for my undergraduate degree.

7 And then my mother developed a brain cancer,
8 and I decided watching the neurosurgeon talk to my dad
9 during -- after the surgery, I said, "I want to be a
10 surgeon."

11 Q. That experience led you to become a surgeon?

12 A. Yes.

13 So, I said, "Man, I want to be a surgeon. I
14 want to be like that guy."

15 And so that was my goal when I went to medical
16 school, to become a surgeon. Actually, I wanted to be a
17 neurosurgeon, but I decided I prefer to be a general
18 surgeon, so.

19 Q. And is that what you are today?

20 A. I am a general surgeon today.

21 Q. And what does that mean that you're a general surgeon?

22 A. So, a general surgeon sounds like exactly what it means
23 to some extent, general meaning we are not focused on
24 the brain and stuff like that because we don't do brain
25 surgery, we don't do orthopedic surgery. We do surgery

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1 of the bowels, of the breast, of soft tissues. We do
2 trauma surgery. We do weight loss surgery, hernia
3 surgeries, colon surgeries, colostomies, meaning
4 creating colostomies and reversing colostomies. We
5 do --

6 Q. How many of those have you done? Like, we're here to
7 talk about a colostomy surgery, right, that was
8 originally done, and then a reversal that was done by
9 you. How many of these reversals have you done in your
10 career, Doctor?

11 A. Yeah, it's hard to say. I mean, I'll guesstimate that I
12 do about one to two reversals a month, maybe 18 a year,
13 and I've been in practice for 26 years. So if you want
14 to take a rough estimate, it would be about 26 years
15 multiplied by 18, and that would give you a rough
16 estimate of how many colostomy reversals I've done.

17 Q. Now, I went to law school because I wasn't very good at
18 math, but hundreds, is that --

19 A. Hundreds, yes.

20 Q. Hundreds?

21 A. It would be in the hundreds ballpark area.

22 Q. And how long have you been practicing?

23 A. I've been in practice 26 years, but I also did seven
24 years of residency so I've been a doctor for 33 years.

25 Q. Did you ever teach medical students, future doctors of

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1 America and of the world?
 2 A. Yes. So, I was in an academic group until December of
 3 last year. I worked for Wayne State University or Wayne
 4 Health, and I was responsible for teaching residents.

5 Q. These are students at Wayne State Medical School?

6 A. So, I was responsible for teaching both medical students
 7 who are not doctors yet, they're on the pathway to
 8 become doctors after they matriculate for four years in
 9 medical school. So, I taught medical students in the
 10 third and fourth year, meaning their second to last
 11 year -- last year of medical school, and then I teach
 12 residents.

13 Now, residents, although they're not
 14 full-fledged surgeons, surgical residents are in
 15 surgical training. And depending on, you know, what
 16 program they're in, whether it's a five-year or
 17 seven-year program, I teach residents at all levels,
 18 meaning from interns, meaning a first-year resident to a
 19 chief resident.

20 And then I developed what we call a minimally
 21 invasive bariatric surgery fellowship, only one of three
 22 in Michigan. It was the second in Michigan when I
 23 developed it in 2008. And I taught one fellow a year
 24 who had completed residency and was now getting what we
 25 call subspecialty post-residency training. And

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1 actually --

2 Q. Are you still teaching fellows --

3 A. I am.

4 Q. -- here at the hospital?

5 A. I am. I've stepped down as the program director of the
 6 fellowship, and my last fellow will be graduating in two
 7 days.

8 Q. Congratulations.

9 A. So, and then I'll start just as an adjunct member of
 10 the -- I won't be as much into the teaching of bowels
 11 starting August the 1st of this year.

12 Q. And you used to be the chief of surgery.

13 Here's your CV. It's marked as Plaintiff's --

14 A. I was.

15 Q. -- 106.

16 PLAINTIFF EXHIBIT NO. 106

17 Dr. Webber's Curriculum Vitae (16 pages)

18 WAS MARKED FOR IDENTIFICATION

19 A. I was the chief of surgery at Harper from February of
 20 2010, I believe, until July of last year.

21 Q. Director of the surgery program, you told us about that?

22 A. Right.

23 Q. And, Doctor, are you what's called board-certified?

24 A. I am board-certified.

25 So, board certification in the United States

1 is fairly necessary to essentially practice in most
 2 settings; meaning, when we achieve board certification,
 3 we have to take a test which is a written test that we
 4 have to pass, that all surgical residents will take.
 5 And I'm sorry. Yeah. All surgeons will take. And then
 6 an oral board examination that is administered by, you
 7 might say, seasoned and experienced surgeons to make
 8 sure that you meet the certification to be a qualified
 9 surgeon in the United States.

10 So, board certification is very important to
 11 be able to practice in the field of surgery and not to
 12 be limited as to where you can practice.

13 Q. And you said that you practiced in the board of surgery.
 14 It looks like here's your board certification. You were
 15 recertified.

16 What does it tell you about being a surgeon
 17 and being board-certified? You described it as fairly
 18 necessary. Does it tell you anything as a doctor that
 19 the defendant in this case, Dr. Papendick, was not
 20 board-certified at the time that he was making surgical
 21 decisions for outpatient care?

22 MS. WEIL: Objection. Foundation,
 23 argumentative.

24 A. Was --

25 Q. Go ahead.

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1 A. -- Dr. Papendick a surgeon?

2 Q. No, he was not.

3 A. Well, what kind of physician is he, if I might ask?

4 MS. WEIL: Objection. The witness is asking
 5 questions.

6 MR. MARKO: Yeah. That's okay.

7 BY MR. MARKO:

8 Q. I want you to assume that Dr. Papendick is not a
 9 surgeon, and not only is he not a surgeon, that he's not
 10 board-certified, but that the defendant corporation put
 11 him in charge of the utilization management decisions --

12 MS. WEIL: Objection.

13 Q. -- does that --

14 MS. WEIL: Foundation, argumentative.

15 Q. -- what does that tell you --

16 MR. MARKO: Excuse me. Can I please finish?

17 MS. WEIL: I'm sorry. I didn't --

18 MR. MARKO: You're interrupting me --

19 MS. WEIL: I thought you were finished.

20 MR. MARKO: -- in the middle of my questions.

21 MS. WEIL: I wasn't. I thought you --

22 MR. MARKO: It's unprofessional.

23 MS. WEIL: -- were finished.

24 BY MR. MARKO:

25 Q. I want you to assume, and the jury will hear in this

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1 case, that Dr. Papendick is not a surgeon, not only is
2 he not a surgeon but he is not board-certified, yet he
3 is making decisions and making recommendations on
4 surgery for outpatient purposes. What does that tell
5 you, Doctor?

6 MS. WEIL: Objection. Foundation,
7 argumentative.

8 Q. Go ahead.

9 A. Am I allowed to answer?

10 Q. Yes.

11 A. Okay. So, I think the fact that he's not
12 board-certified in any field is very suspect. I think
13 it's very strange not to be board-certified in any field
14 of medicine whether it be family practice, internal
15 medicine, or surgery.

16 I think it's hard for a person, one, who is
17 not board-certified and, two, who is not a surgeon to
18 make medical decisions regarding the medical necessity
19 whether somebody needs a surgical procedure or not.

20 Q. Why?

21 A. Because they're not qualified and they're not an expert.
22 It's not their wheelhouse. They have no business making
23 those decisions.

24 MS. WEIL: Objection. Assumes facts not in
25 evidence.

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1 Q. Now, going back to your qualification -- oh, it looks
2 like you were Top Doc by Our Detroit Magazine. What
3 happened? 2021, you dropped off?

4 A. I know I put 2025 [sic] as the date, but I have been Top
5 Doc every year.

6 Q. Oh, so this is --

7 A. So, I just --

8 Q. -- just not updated?

9 A. It's not really updated.

10 Q. All right. Okay. So, that's good.

11 And you were in the military. Tell the jury
12 about that, Doctor, and thank you for your service by
13 the way.

14 A. So, I joined the United States Army as a reservist as a
15 volunteer because America has been good to me. I had an
16 opportunity to get educated in the United States, to
17 become a doctor in the United States, and I felt that I
18 owed the United States something back after 9/11. So I
19 volunteered to serve in Iraq, and I was deployed to Iraq
20 with a forward surgical team from Fort Snelling,
21 Minnesota, where I took care of injured soldiers in 2003
22 in Iraq.

23 Q. So, you were -- were you in like a combat --

24 A. I was in a -- what we call a forward surgical team. It
25 was a 20-person team made up of three general surgeons

1 and one orthopedic surgeon, multiple nurses, and some
2 support people who had a mobile unit. We could pick up
3 and be out in six hours to a combat area to treat
4 casualties.

5 Q. Are you sleeping in tents and stuff like that or...

6 A. We're on the ground.

7 Q. On the ground?

8 A. At times.

9 Q. Doctor, thank you for your service.

10 A. Thank you.

11 Q. I appreciate it on behalf of my client.

12 MR. MARKO: And at this time, I move to
13 qualify Dr. Webber as an expert in his respective fields
14 of general surgery.

15 MS. WEIL: No objection.

16 DIRECT EXAMINATION BY MR. MARKO:

17 Q. Okay. Doctor, let's talk about Mr. Jackson, why we're
18 here. Do you remember -- I know you've seen -- you've
19 probably treated a lot of patients and tried to heal
20 them in your career?

21 A. I have.

22 Q. Do you remember Mr. Jackson?

23 A. Vividly.

24 Q. Vividly? Tell the jury, how is it that of all the
25 patients that you've treated and tried to help and heal

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1 over your career, Doctor, that you remember Mr. Jackson?

2 A. Solely because of his name.

3 Q. What is that? What's his name?

4 A. So, I'm a historical buff. And when I first met him,
5 he's an African American, at least, you know,
6 externally, he looks African American to me, and he had
7 the name of Kohchise, and I knew Cochise was an Apache
8 chief.

9 And so I literally asked him, I said, "How did
10 you get the name Kohchise?"

11 And he told me he was part Indian, I believe,
12 and that's how -- why he was named of Kohchise, which
13 I've never in my life seen a person named Cochise except
14 in the historical record of the Apache Chief Cochise.

15 Q. Yeah.

16 A. And it's not spelled the same, but phenotypically -- or
17 phonetically, it sounds the same.

18 Q. Yeah. And do you -- and so you remember Mr. Jackson?
19 Did he -- was he -- can you just describe his demeanor?
20 I'm sure you see all kinds of different patients, some
21 cranky, some --

22 A. Sure. So --

23 Q. -- nice?

24 A. -- I knew -- I think he was very upfront with me and he
25 told me he was -- had been released from the department

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1 of corrections or prison. I don't know if he said
 2 department of corrections, but he had told me that, you
 3 know, upfront that he had been released from prison.
 4 So, you're always a little bit leery with
 5 prisoners because, you know -- whatever. Anyway, he was
 6 a nice guy. And I was, you know, pleasantly surprised
 7 at how nice he was. He was genuinely a nice guy, and,
 8 you know, I remember, you know, having pleasant
 9 conversations with him during his hospital stay,
 10 postoperatively, and even before the surgery.
 11 Q. And if we look at the timeline here which is a
 12 demonstrative, it looks like he was released on May 16th
 13 of 2019. He was able to get in the OR with you --
 14 A. Yeah. We saw him in my clinic on Friday, May the 31st
 15 of 2019.
 16 Q. Two weeks after he was let out of prison?
 17 A. Roughly 15 days after discharge from the prison.
 18 Q. And so 15 days after getting released, he was in your
 19 office in where? Commerce Township or --
 20 A. No. He actually saw me at Harper.
 21 Q. Harper?
 22 A. Yes.
 23 Q. Okay.
 24 A. Which is downtown Detroit.
 25 Q. Downtown Detroit?

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1 A. M-hm.
 2 Q. And then you were able to get him in the OR to do this
 3 reversal on June 19th, 2019. So, within a month or
 4 almost a month?
 5 A. A little bit over a month of his release, yes.
 6 Q. Now, Doctor, you said you've done hundreds of these
 7 surgeries. Would you ever do a surgery on someone like
 8 Mr. Jackson if you didn't feel that it was medically
 9 indicated?
 10 A. No. That would not be appropriate to perform
 11 non-medically indicated operations. Like I said, I
 12 believe the colostomy reversals are medically indicated
 13 and necessary so it was indicated to reverse his
 14 colostomy. Most people do not want to maintain their
 15 colostomies longer than they have to.
 16 Q. And we'll talk about that and why not, but for
 17 Mr. Jackson, did you have any qualms? Did you say, you
 18 know, did you have -- you know, think to yourself:
 19 Well, you know what, maybe he should just keep this
 20 colostomy forever? Did you ever have any second
 21 guessing of yourself?
 22 MS. WEIL: Objection. Leading.
 23 A. First of all, again, as I said earlier, colostomies, if
 24 the patient is in good health and has some longevity to
 25 them, meaning they're not -- you know, I don't think I

1 would reverse a colostomy in somebody who is over
 2 90-years-old unless they were really in good health, but
 3 if they have longevity in their life -- or they have
 4 life expectancy and they're in good health and there's
 5 no medical contraindication to reversing them, they
 6 don't have terminal cancer or something like that, they
 7 should be reversed.
 8 So, I never even thought twice about not
 9 offering him reversal. I think reversal was indicated,
 10 and as a medical provider, I thought that's the least I
 11 could do is to offer him my expertise in reversing his
 12 colostomy.
 13 Q. Was it an easy decision?
 14 A. It was, because there was no algorithm of really
 15 thinking about it. Here's a man with a colostomy. He's
 16 young. I think -- how old was he at the time?
 17 Q. He was in his 30s.
 18 A. Okay. He was in his 30s. I don't think anybody in
 19 their 30s wants to -- if his life expectancy is 75 to
 20 80, I don't think it would be fair to have a colostomy
 21 for that long. So --
 22 Q. Did he have any health issues that made you think: You
 23 know what, there might be -- we might need to take a
 24 second look at this?
 25 A. I don't believe so because he was young enough,

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1 meaning -- I think, you know, in my clinics, if the
 2 patient is over 50, we are going to cardiac clear them
 3 and send them for clearances. People who are sub-50 or
 4 under 50, we assume are -- and we'll ask them, you know,
 5 we take an appropriate history.
 6 Q. Right.
 7 A. We take an appropriate history and ask them. You know,
 8 there are some people who are sub -- or under 50 who are
 9 medical train wrecks and may not be candidates for
 10 reversal. Let's say a patient with terminal cancer at
 11 age 28 who has a colostomy and has a limited life
 12 expectancy, I would not offer them a colostomy reversal.
 13 But a person like Kohchise whose colostomy was
 14 placed on him for benign disease, it is indicated to
 15 reverse his colostomy.
 16 Q. Was Mr. Jackson eager to get that bag off?
 17 A. Oh, I would say it was an underestimate. And, again,
 18 he's not really different than a lot of patients, even
 19 older patients of mine. I literally reversed a
 20 colostomy two weeks ago in a 77 year old. She was very
 21 eager to have it reversed. People don't want a
 22 colostomy. They don't want to wear it for a day longer
 23 than they have to.
 24 Q. Let me show you...
 25 MR. MARKO: Can we go to this? How do I do

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1 that? Is it easy to switch over?

2 THE VIDEOGRAPHER: I don't have it switched

3 that way where he can see it on the monitor. I would

4 have to do some switching around, because I had to do it

5 at the last second.

6 MR. MARKO: Well, can we show the jury, and

7 then I'll reference the exhibit here?

8 THE VIDEOGRAPHER: Yeah, the jury will see it.

9 BY MR. MARKO:

10 Q. All right. So, let's switch to this. I'm going to

11 reference to you Exhibit 2, Plaintiff's Exhibit 2. This

12 is admitted into evidence by stipulation of the party,

13 and this is a letter by the woman named Dr. Kansakar.

14 Do you know Dr. Kansakar?

15 A. I do.

16 Q. And she's a surgeon?

17 A. She is a board-certified general surgeon.

18 Q. And the jury's gonna hear from her in this case, and

19 Dr. Kansakar is the doctor who did the original

20 colostomy surgery where the bag was attached on

21 Mr. Jackson in December of 2016.

22 A. That's what the record states, yes.

23 Q. Now, Dr. Kansakar, in Exhibit 2, which the jury's gonna

24 see, wrote a letter that says (as read): "My

25 recommendation and the standard of care for this patient

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1 is to have an X-ray via the distal rectal stump and a

2 colostomy reversal. Please see attached note."

3 Do you agree with the board-certified treating

4 physician who wasn't hired by anybody in this case, that

5 Mr. Jackson's -- it was medically indicated to have, and

6 the standard of care required, a colostomy reversal

7 surgery?

8 MS. WEIL: Objection. Argumentative.

9 Q. Go ahead. Do you agree with her?

10 A. I believe after you defined the standard of care is what

11 the average general surgeon of average learning,

12 intelligence, training, and expertise would do in given

13 a similar circumstance, this is what all general

14 surgeons would do. It would be to reverse this

15 colostomy.

16 Q. Thank you, Doctor.

17 We can go back to this now just for the jury.

18 Okay. Now, Doctor, what if somebody were to say, "Well,

19 you know what, he had on this colostomy bag so what's

20 the big deal? It wasn't medically necessary." Would

21 you agree with that?

22 MS. WEIL: Objection. Leading, argumentative.

23 Q. Would you agree if the defense says in this case that he

24 could have -- you know what? Let's go. We'll make this

25 real easy. Let me show you which has been -- is gonna

1 be admitted as an exhibit from Dr. Papendick.

2 MR. MARKO: Is that -- are we ready?

3 THE VIDEOGRAPHER: It's black. You don't have

4 anything up there.

5 MR. MARKO: So, it's not playing?

6 THE VIDEOGRAPHER: No. Because it's --

7 MR. MARKO: Oh, here we go.

8 THE VIDEOGRAPHER: Okay. I see it.

9 (Video playing.)

10 MR. MARKO: There's no sound, though.

11 THE WITNESS: Maybe you have to unplug the

12 white cord.

13 MR. MARKO: Can we just go off the record for

14 a second and fix this?

15 (Video stops.)

16 THE VIDEOGRAPHER: Going off the record at

17 5:07 p.m.

18 (An off-the-record discussion was held at 5:07

19 p.m.)

20 (Back on the record at 5:10 p.m.)

21 THE VIDEOGRAPHER: We're back on the record at

22 5:10 p.m.

23 (Video playing and transcribed as follows:

24 "QUESTION: So, if a patient has a colostomy

25 bag and a life sentence, do you think that

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1 they should never have it reversed unless --

2 as long as the colostomy is functioning?

3 "ANSWER: If the colostomy is functioning

4 with no issue whatsoever, yes, he should

5 continue to have his colostomy.

6 "QUESTION: For his whole life?

7 "ANSWER: If that's what it takes.")

8 (Video stops.)

9 BY MR. MARKO:

10 Q. Doctor, do you agree with Dr. Papendick that this can be

11 left, these colostomy surgeries, without reversal, in

12 someone like Mr. Jackson for the rest of his life?

13 MS. WEIL: Objection. That's not what the

14 testimony said. Assuming facts not in evidence.

15 Q. Well, do you agree -- let me rephrase. Do you agree

16 with what Dr. Papendick testified to?

17 A. I believe he testified that a person who has a life

18 sentence -- I believe the question was: "Can a person

19 who has a functioning colostomy with a life sentence

20 continue to wear his colostomy for the duration of his

21 imprisonment?"

22 And he said yes. I completely disagree with

23 that.

24 Q. Why do you completely disagree with Dr. Papendick?

25 A. Because a colostomy can cause a patient harm in the

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1 future and develop complications. And we like to
 2 practice preventative medicine, and preventative
 3 medicine would be to reverse the colostomy in a timely
 4 fashion, when it's medically suitable to reverse it.
 5 And most colostomies can be reversed about six months.
 6 Some earlier, some a little bit later, but sometime
 7 in -- time period around six months after the original
 8 surgery that placed the colostomy, and to delay it is an
 9 central risk of harm to the patient.

10 Q. Were you able to see through your review, history,
 11 review of records, everything that you did in this case,
 12 any reason to delay the colostomy reversal of
 13 Mr. Jackson?

14 A. Not at all.

15 Q. You said that it poses a risk of harm not to get it
 16 reversed. Now, you talked about two types of harm;
 17 physical and emotional harm -- sorry. Psychological and
 18 emotional harm, and physical harm?

19 A. Correct.

20 Q. Okay. So, let's talk about psychological harm to have
 21 this thing. Here's a demonstrative that the jury's
 22 gonna see, okay? Do you agree that a -- can a colostomy
 23 bag -- and I know that's not the technical medical --
 24 what is it? It's a -- a stoma?

25 A. Yeah. It's a stoma.

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1 Q. It's a stoma?

2 A. Yeah.

3 Q. With a bag cause physical discomfort and health
 4 challenges?

5 A. Yes. Absolutely. I mean, it's -- first of all, you're
 6 wearing a bag on the outside of your body. So, when
 7 you -- you can't wear tight-fitting clothes at all
 8 because it would show. Most people wear baggy clothes.

9 You have to apply some kind of adhesive to the
 10 skin around the stoma in order to have the appliance
 11 stick to the stoma. So, you can develop contact
 12 dermatitis there, skin excoriation there, even a rash
 13 and bleeding from that appliance. You can develop skin
 14 irritation.

15 And one of the biggest complications of a
 16 colostomy that we didn't even mention is leakage of the
 17 bag, so.

18 Q. Tell us about that.

19 A. The skin surface is not always flat, okay? Someone --
 20 when you look at my belly, there are rolls to my belly,
 21 and when you put the colostomy bag, you might say in an
 22 area where there is a depression in the skin from a
 23 roll, the bag has a hard time fitting and so the bag
 24 leaks.

25 Q. I want you to assume that in this case, Mr. Jackson, and

1 the records are going to show, that there were occasions
 2 where feces would leak out of the bag and onto him like
 3 when he was out in the yard. Is that consistent with
 4 your experience of what can happen?

5 A. It happens in every patient with a colostomy. Despite
 6 our best efforts to locate the colostomy in the best
 7 place possible for the patient, colostomy's always leak.
 8 And it's a -- they're a nightmare scenario for the
 9 patient, and the leakage is, obviously, as you can
 10 imagine, extremely foul.

11 Q. Tell us.

12 A. Well, you're leaking stool onto your skin. And stool on
 13 the skin is not only unsanitary, but it smells bad, it
 14 can permanently stain your clothes, and patients have
 15 had to get rid of clothes for staining of their clothing
 16 because of the leakage.

17 But leakage is part and parcel of what
 18 colostomies do because, again, we weren't born with
 19 these. We weren't meant to have these on, but they are
 20 an end to a means, and survival is key in people with
 21 ruptured diverticulitis such as Mr. Jackson had.

22 So, colostomies were meant to be a temporary
 23 procedure in most instances, unless we have a
 24 conversation with the patient where we're, you know,
 25 talking about a permanent colostomy. But, you know, in

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1 any of these colostomy procedures that patients consent
 2 for, the patient's inevitably will ask, "Is this a
 3 temporary bag?"

4 And the answer is, "Yes, in all instances,
 5 unless we've removed the mechanism of anal defecation
 6 which is the anus and rectum."

7 These bags are meant to be temporary, and
 8 there is not only a verbal understanding with the
 9 patient that it's temporary, but in the medical
 10 community, there's an implicit understanding that these
 11 bags are temporary. Or stomas are temporary.

12 Q. Now, the other issues. You talked about these potential
 13 for rash, irritation, leakage of the bag, the smell.
 14 What about -- how does this affect somebody's
 15 interactions with other people, like, socially? Do
 16 you -- is there social stigma and isolation that can
 17 occur?

18 A. There is. Because, again, these bags burp, you might
 19 say, gasses from the colon which we would called flatus
 20 or flatulence.

21 Q. What do you mean they would burp gasses? Is that like
 22 passing gas?

23 A. They pass gas into the bag without any warning, and
 24 they're often very noisy. And so a patient who has a
 25 colostomy, I've seen them in my clinic, will sit there

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1 and pass gas in front of me, and they're always very
2 embarrassed.

3 And they say, "Excuse me, Doctor. I'm sorry."

4 And I tell them, "Listen, I put the bag on
5 you. I understand. You have no control over your
6 flatulence."

7 People with a -- who don't have a colostomy
8 have control of their flatulence because they have an
9 anal sphincter mechanism that they can squeeze to
10 tighten so that the flatus doesn't come out and cause
11 them to be socially ostracized, you might say, or
12 embarrassed.

13 Q. So, how does that work when they pass gas and have a
14 colostomy bag? Because it's your intestine, right,
15 that's going out?

16 A. It's your -- the gasses from your colon that are being
17 passed through the -- so the big fills up and --

18 Q. With gas? With gas?

19 A. Gas. With --

20 Q. Smelly gas?

21 A. Absolutely smelly gas.

22 MS. WEIL: Objection.

23 A. It's flatulence. It fills up with --

24 Q. Is it smelly gas?

25 A. It is --

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1 MR. MARKO: What's the objection?

2 MS. WEIL: You're leading him. You're putting
3 words in his mouth.

4 BY MR. MARKO:

5 Q. What type of gas is it? What does it smell like?

6 A. It smells like, for lack of a better word, a fart.

7 Q. And this -- does the person have any control over their
8 ability? Like as human beings --

9 A. Zero.

10 Q. -- do people generally hold them in?

11 A. Yes. Well, if I'm alone, I'm gonna let it out and it
12 doesn't matter.

13 Q. Okay. All right.

14 A. But if I'm -- if I need to --

15 Q. Fair enough.

16 A. -- do it here right now in front of a jury trial, I'm
17 gonna hold it in.

18 But a person with a bag has zero option for
19 that. They are going to expel the air. As soon as that
20 air develops and wants to come out, there's zero control
21 over that. There's no sphincter at the stoma, zero
22 sphincter control.

23 Q. And so if the records show, and Mr. Jackson testifies,
24 that as a result of this bag, that it smelled around him
25 and caused him to even be physically assaulted, do these

1 bags, can they emanate a smell when they leak or when
2 gas is passed?

3 A. Yes.

4 Q. Can that cause social stigma, isolation, or even harm if
5 you're in a prison environment, for example?

6 A. Again, it certainly could. Again, I'm not around
7 prisoners so I wouldn't know.

8 Q. Right.

9 A. But they're there for reasons so though they might not
10 like somebody passing gas around them.

11 Q. All right. What about emotionally? Does having to have
12 this bag, can that cause emotional or psychological
13 burden?

14 A. I said that earlier, that there is emotional harm caused
15 by the presence of an appliance. Again, people are
16 embarrassed by it. They don't feel it's natural which
17 it isn't. They don't feel -- a lot of them don't feel
18 it's a part of them, and some of them are even afraid to
19 look at it.

20 Q. What do you mean? Tell me about that.

21 A. Well, I mean, looking at it. And it's literally a part
22 of your inside sticking out of you, and so it doesn't
23 look like anything that they've ever seen before or
24 experienced before. And to watch it burp stool out
25 is -- the first time they see it, I would tell you that

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1 most of them are taken aback by it.

2 Q. Let me show you a record. This is MDOC record 72. It's
3 in evidence by stipulation with regards to that. It
4 says here -- this is for Mr. Kohchise Jackson. See that
5 right there?

6 And it says that he stated, "I am only

7 35 years old and I cannot have this my whole life."

8 Is that type of comment consistent with what
9 you see in these -- with not getting a reversal surgery?

10 A. I see it in patients who are 77 years old. I told you I
11 reversed a -- they don't -- well, a 77 year old has less
12 life expectancy than Kohchise at 35. That 77 year old
13 didn't want their bag there a minute longer than she had
14 to have it.

15 Q. Okay. Well, now, we talked about the emotional toll
16 that you said. What about lifestyle restrictions and
17 daily challenges? Do you have to alter your lifestyle
18 at all? Are there special restrictions?

19 A. There is lifestyle restrictions. Some people, again,
20 will limit the type of foods they will eat because
21 certain foods will transit through the colon faster than
22 others. And so, obviously, if you're going to go to a
23 function or a party, some people would not eat before
24 that because they don't want the bag to be erupting
25 during the party or during the function that they're at

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1 like a concert or a movie.
 2 Obviously, I mentioned the swimming pool
 3 example. People who have colostomies, you don't see
 4 them at the pool. You ever see anybody with a colostomy
 5 at the pool walking around with a bag exposed hanging
 6 off their belly? No, you're never gonna see that.
 7 Q. What about interfering -- like, Mr. Jackson will testify
 8 that, you know, he'd go and try to lift weight --
 9 obviously, at corrections, at least I don't think so, I
 10 don't think they have very nice pools there. But, you
 11 know, like, he'd go lift weights. He's gonna testify
 12 that, and the records will show that, you know, he'd go
 13 lift weights and try to exercise because he's in prison,
 14 and the feces would start leaking out. Is that
 15 consistent with what you see?
 16 A. Absolutely. Increases in intra-abdominal pressure
 17 caused by weight lifting would tend to make stool come
 18 out.
 19 Q. And what about body image issues? Is that something
 20 that can be a psychological harm of a colostomy bag?
 21 A. Well, I think that's obvious to the average person that
 22 a colostomy is a negative factor in body image and how
 23 somebody perceives their body image.
 24 Q. What about physical harm? You said that -- we talked
 25 about the psychological and emotional. You said that a

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1 delay of not getting this reversal can cause physical
 2 harm and you listed some things. Can we go through
 3 those? What are the -- what are high-risk physical
 4 harms for not letting somebody get this surgery?
 5 MS. WEIL: Objection. Asked and answered.
 6 Q. No. Go ahead.
 7 A. Okay. So, the one that I would point out mostly would
 8 be the development of what we call a parastomal hernia.
 9 So, it would be the exception or the exceptional
 10 colostomy that did not develop a hernia around it. And,
 11 again, a hernia is the hole in the fascia surrounding
 12 the actual stoma as the stoma transits from the
 13 abdominal cavity onto the skin.
 14 Again, we try to make those holes so that
 15 they're snug, but over time, physics and mechanics allow
 16 for these holes to get larger. And so now you have a
 17 large defect that's only occupied in one part of it by
 18 the actual stoma or the colon itself, and that allows
 19 bowel to get into the colostomy and literally --
 20 literally cause an obstruction.
 21 So, I recently did an emergency bowel surgery
 22 on a patient who had a complete bowel obstruction from a
 23 previous colostomy.
 24 Q. What other physical risks of harm are there to not
 25 getting a reversal?

1 A. Well, again, let me just finish up with the bowel
 2 obstruction --
 3 Q. Oh, I'm sorry.
 4 A. -- issue.
 5 Q. I'm sorry.
 6 A. So, the bowel obstruction issue -- bowel obstructions
 7 are at times surgical emergencies because if the bowel
 8 is stuck and incarcerated in the -- and we call it
 9 literally incarceration of the bowel, in the colostomy
 10 site, the bowel gets in there, gets swollen, and then
 11 just gets stuck, and it can't be physically -- or the
 12 patient can't reduce it themselves.
 13 And so the bowel can then turn gangrenous
 14 because if it's incarcerated, it might become
 15 strangulated, meaning the blood supply is choked off to
 16 that loop of bowel, and then the bowel will die. And
 17 then that becomes a very life-threatening condition and
 18 requires immediate and emergent medical or surgical
 19 intervention to correct the bowel obstruction and to fix
 20 the actual hernia itself.
 21 So, that's one potential complication or a bad
 22 outcome of a colostomy. The other is a development
 23 which I alluded to earlier of a prolapsed colostomy
 24 where the --
 25 Q. What does that mean?

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1 A. Where the bowel -- the mucosa -- the bowel has several
 2 layers. The inner layer of the colon itself is called
 3 the colonic mucosa. And sometimes, for whatever reason,
 4 the mucosa literally pops through and you literally have
 5 these long -- I think I saw a picture of one of those.
 6 Q. Yeah. Let me show you this as an example. Would this
 7 be an example?
 8 A. That is a perfect example of a colostomy prolapse.
 9 MS. WEIL: Objection. Objection to the
 10 exhibit. Objection to the question. Objection on
 11 relevance, and 401, 403. There is no evidence that
 12 Mr. Jackson had any of this. This is irrelevant, this
 13 is prejudicial, and we object to the entire line of --
 14 MR. MARKO: Okay. So --
 15 MS. WEIL: -- testimony.
 16 MR. MARKO: -- let me just respond to this for
 17 Judge Drain's ratification when he's ruling on this
 18 objection.
 19 So first of all, this is a case about whether
 20 the defendant was deliberately indifferent to
 21 Mr. Kohchise's legitimate medical need. As you know,
 22 the defense in this case has been, since the beginning,
 23 that it was not medically necessary for Mr. Jackson to
 24 get this, that he didn't need it, for lack of a better
 25 term, that it was just an elective surgery that he

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1 didn't need. As Dr. Papendick testified to and will
2 testify to at trial, that he didn't meet the criteria
3 for getting this surgery because there was "no risk of
4 harm" to Mr. Jackson. That's what he said in his
5 deposition. We can play the clip, and I will play the
6 clip.

7 And that's just not true as demonstrated by
8 this doctor's testimony related to the various risks of
9 harm. We don't Monday morning quarterback this and say,
10 "Well, what did or didn't happen to Mr. Jackson?" What
11 we do is we say, "At the time that the decision was
12 made, what are the risks and ramifications of not
13 getting the surgery?" It was recommended by
14 Dr. Kansakar. There is no other treating doctor that
15 said that it wasn't, and the defense is that he just
16 didn't need it and that there was no harm.

17 Dr. Webber is clearly testifying, and I'm
18 gonna continue to ask him questions because it's
19 relevant, it rebuts the defense -- this ridiculous
20 defense in this case that Mr. Jackson's surgery was not
21 necessary and that there was no risk of harm.

22 So, that's why it's relevant. This exhibit is
23 relevant for many reasons. Number one, it's admissible
24 as substantive evidence because it shows -- for the
25 Monell claim, it shows from another patient what

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1 happens. It's relevant as a demonstrative exhibit to
2 show what happens, what the risk of harm is. Because
3 this is something that Dr. Papendick should have been
4 considering, was required to consider when he was
5 denying Mr. Jackson's reversal surgery.

6 So, your objection's made. The judge can rule
7 on it. I'm going to continue to show this, and I'm
8 gonna ask questions about it.

9 MS. WEIL: I'm gonna move to strike that
10 entire speech. That was your closing argument,
11 congratulations, but I'm gonna move to strike the entire
12 speech. That is not a response to an objection. It's
13 entirely inappropriate in this context. You've assumed
14 facts not in evidence. You have speechified about
15 things we haven't even heard yet in this case and may
16 not hear in this case. You're characterizing testimony.

17 MR. MARKO: Okay.

18 MS. WEIL: And I'm moving to strike the whole
19 speech and --

20 MR. MARKO: Okay. Yeah. Well --

21 MS. WEIL: -- the objection stands.

22 MR. MARKO: -- I mean, Counsel, my objections
23 and speech -- my response to your objection is --

24 MS. WEIL: My objection was proper; your
25 speech was not.

1 MR. MARKO: Excuse me. Now you're
2 interrupting me.

3 MS. WEIL: Yes, I am.

4 MR. MARKO: You know, and this is about the
5 third time you've done it in this deposition. It's very
6 rude and unprofessional. I don't know why you would --
7 why do you insist on interrupting me when I'm trying to
8 respond? I've been nothing but courteous to you, I've
9 been respectful, and I haven't interrupted you. You
10 need to stop. It's not appropriate. And I'm not gonna
11 allow it to happen. And it's disrespectful to me and
12 it's disrespectful to the doctor and it's disrespectful
13 to the court.

14 Now, I'm gonna proceed.

15 MS. WEIL: How -- excuse me. How --

16 MR. MARKO: Excuse me.

17 MS. WEIL: -- am I supposed --

18 MR. MARKO: Excuse me.

19 MS. WEIL: -- to stop the speech without
20 interrupting you?

21 MR. MARKO: Ma'am, ma'am --

22 MS. WEIL: Am I just supposed to let you --

23 MR. MARKO: Ma'am --

24 MS. WEIL: -- keep speechifying?

25 MR. MARKO: Ma'am --

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1 MS. WEIL: Am I just supposed to let you --

2 MR. MARKO: Ma'am --

3 MS. WEIL: -- keep talking?

4 MR. MARKO: Ma'am --

5 MS. WEIL: No.

6 MR. MARKO: Tell me when you're done, ma'am.

7 Tell me --

8 MS. WEIL: No. You tell --

9 MR. MARKO: -- when you're done.

10 MS. WEIL: -- me when you're done because I'm
11 not gonna let you just keep giving speeches by telling
12 you -- that I am forbidden from interrupting you. Can
13 we get back to the questioning? I mean, this is not
14 helping anybody.

15 MR. MARKO: Are you done, ma'am?

16 MS. WEIL: I -- if you are.

17 BY MR. MARKO:

18 Q. Okay. So, as I was saying -- Doctor, I'm so sorry about
19 that.

20 So, Doctor, as I was saying, so you were
21 describing a risk, a potential complication of not
22 getting this reversal. Is this something that a medical
23 provider should take into consideration, potential
24 risks, when they're making a decision on whether someone
25 should get a colostomy reversal?

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1 A. Well, again, the medical provider who should opine about
2 whether a patient needs a colostomy reversed or not
3 should really be a surgeon because I don't think a
4 provider who is not a surgeon has any idea whatsoever
5 what the potential complications of having a colostomy
6 in place are.

7 So, this is a prolapse, looking at this
8 picture, which I don't believe Mr. Jackson had but this
9 is what could potentially happen. This is obviously the
10 herniation of mucosa through -- and you can see that
11 it's very long, and so that makes the placement of a bag
12 somewhat difficult because these bags aren't that long,
13 usually. So, it's hard to get an appliance over it and
14 to keep the appliance over it.

15 And then these prolapses desiccate because
16 they're stuck out like this. And so they become
17 problematic and they get irritated because of
18 desiccation, and they bleed. So, bleeding is a
19 complication of this prolapse.

20 But the biggest problem with the prolapse is
21 that if it gets too large like this one, it'd be -- it's
22 hard to get the stool to come through there. And they
23 could develop an obstruction just from the prolapse, and
24 that would require emergent surgical intervention.

25 Q. So, this condition that we see right here, was this a

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1 risk that Mr. Jackson would have faced for not getting a
2 timely reversal?

3 A. I would go one -- the answer is yes, but I would go one
4 above it and say that any patient with a colostomy is at
5 risk for this complication.

6 Q. And is that something that a provider needs to consider
7 when they're deciding whether to do a reversal or not?

8 A. Well, any surgeon would know that this is a potential
9 risk, and that's why we choose to reverse colostomies,
10 and that's why it's medically necessary to reverse these
11 colostomies.

12 Q. Now, Doctor, was there any other physical risks? You
13 told us about these physical risks here that -- was
14 there any other physical risks that were prominent in
15 your mind as it relates to the need for Mr. Jackson's
16 reversal?

17 A. No. These are the most significant risks associated
18 with a colostomy.

19 Q. Now, Doctor, let's talk about, like, the surgery that
20 you ended up doing from a cost-benefit analysis. So I'm
21 gonna show you, this is Plaintiff's Exhibit 13. It's
22 admitted.

23 ///

24 ///

25 ///

1 PLAINTIFF EXHIBIT NO. 13

2 Claims with From Date of Service between Jan 1,
3 2000 and July 15, 2021 for Kohchise Jackson
4 (22 pages)

5 WAS MARKED FOR IDENTIFICATION

6 BY MR. MARKO:

7 Q. Now, when somebody comes and gets an operation at the
8 hospital, it costs money, right?

9 A. I would assume so.

10 Q. Okay.

11 A. I don't deal with the handover of the money, and
12 nobody's ever handed me a check.

13 Q. Right. Now -- I hear you. Now, you said previously, I
14 believe, would you ever perform an operation that you
15 believe was not medically indicated?

16 A. No. No, I would not.

17 Q. Would you ever bill an insurance provider such as
18 Medicaid for a service that was not medically necessary?

19 A. I would not.

20 MS. WEIL: Objection. Foundation.

21 Q. Okay.

22 A. I would not.

23 Q. Why would you not bill Medicaid for a medically
24 unnecessary surgery? Or --

25 MS. WEIL: Objection.

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1 Q. -- in other words -- let me rephrase it. Why would you
2 only bill Medicaid for a medically necessary surgery?

3 MS. WEIL: Objection. Foundation. There's
4 been no foundation laid about Medicaid or about his
5 knowledge of Medicaid or anything else.

6 Q. Go ahead.

7 A. I -- so, obviously, if you provide a medically necessary
8 service, then I think we should be remunerated for that
9 service. So, I think it's completely acceptable to bill
10 insurance carriers for the service provided.

11 Q. All right. So, let's look at how much you got paid.

12 Well, you work for a practice. Did you work for a
13 practice group at the time that you performed the --

14 A. I did. For -- at that time, I believe it was University
15 Physicians Group.

16 Q. All right. So, let's look. This is Plaintiff's
17 Exhibit 13. It's been admitted. So, University
18 Physicians Group?

19 A. Yep.

20 Q. We have Mr. Jackson, Kohchise Jackson over here,
21 6/19/2019. I know that's kind of hard to see. Can you
22 see that?

23 A. I can see it. Yes, sir.

24 Q. Okay. The total amount of the cost of the surgery, the
25 whopping amount was \$919.78?

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1 A. Was the other number --
 2 MS. WEIL: Objection. Argumentative.
 3 A. -- to the left of that, the 5,000 number, was that what
 4 was billed out?
 5 Q. Correct.
 6 A. Was that the charge?
 7 Q. Yep.
 8 A. Okay.
 9 Q. But it looks like that was what was paid.
 10 A. So, was this -- I can't -- am I allowed to ask a
 11 question? Was this Medicare or Medicaid?
 12 Q. It was Medicaid.
 13 A. Okay. So, the Medicaid payment was \$919 on a \$5,000
 14 charge.
 15 Q. Yeah. So, I mean, are these -- were you doing this
 16 surgery for the money?
 17 A. No.
 18 MS. WEIL: Objection.
 19 A. Well, I mean, in the grand sense of being a physician,
 20 we do provide services, and we --
 21 Q. Yeah.
 22 A. -- do get -- we expect payment for the services;
 23 although, I would say that a significant portion of my
 24 patient population, because I work in the inner city of
 25 Detroit, do not pay ever for their services. But the

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1 expected gain is to, you know, get payment for the
 2 service.
 3 So, did I do it specifically for the money?
 4 No. But you, as a physician, expect payment in some
 5 form; although, I don't go chase down the payment.
 6 Q. So, was this a -- given that Plaintiff's Exhibit 13 of
 7 \$919.78 to -- for your Physicians Group to do this
 8 surgery, is this an expensive surgery comparatively
 9 speaking?
 10 MS. WEIL: Objection. Argumentative, no
 11 foundation, no relevance. Objection.
 12 Q. Go ahead.
 13 A. I think the \$919 payout for the complexity of the case,
 14 the preoperative evaluation of the patient, the actual
 15 operation itself and duration and length of the
 16 operation, and again, the complexity of the operation,
 17 and then the postoperative care -- most colostomy
 18 patients like this are in the hospital for about seven
 19 to eight days. And I think that's a very low payout for
 20 the amount of time and investment that I spent in this
 21 particular case.
 22 Q. But you did it anyways?
 23 A. Again, I don't look at the insurances that -- of the
 24 patients that I see. My group takes the insurance.
 25 I'll do the surgery.

1 Q. Would you do surgery on a patient who was -- needed
 2 surgery who was in the department of corrections who was
 3 sent to you?
 4 MS. WEIL: Objection. Relevance.
 5 A. Yes, I would.
 6 Q. Why?
 7 A. Because they're a patient, and just because they're in
 8 the department of corrections doesn't mean that they
 9 need to be treated differently than other citizens of
 10 the country. And so if they have a medically necessary
 11 condition, whether it be the reversal of a colostomy or
 12 the repair of a hernia, these conditions need to be
 13 repaired. And that's why I took a Hippocratic Oath to
 14 be a doctor and a surgeon, and I will do what I believe
 15 is medically necessary on any patient regardless.
 16 Q. And you said that you're not even charging for your time
 17 today? We're here at the hospital. Tell the jury where
 18 we are.
 19 A. We are at Huron Valley Sinai Hospital in Commerce,
 20 Michigan.
 21 And I am not charging for my time nor do I
 22 expect any payment for my time.
 23 Q. Now, do you understand, you're entitled as a medical
 24 professional to be reimbursed for your time?
 25 MS. WEIL: Objection. Leading, argumentative,

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1 irrelevant.
 2 Q. Go ahead.
 3 A. I do understand that I'm entitled to ask for payment for
 4 my time and services here or service or -- no. But I
 5 don't need it; don't want it.
 6 Q. Tell the jury why you're not charging Mr. Jackson for
 7 your time here today.
 8 A. Well, one, because I don't think, from my moral
 9 perspective, that I should charge for this. I believe
 10 that Mr. Jackson should have had his hernia -- or his
 11 colostomy reversed while he was incarcerated because it
 12 was medically necessary. And I don't believe that I
 13 should take money for something that -- for harm that
 14 occurred to a patient, and I just refuse to take the
 15 money.
 16 MR. MARKO: Doctor, thank you so much on
 17 behalf of Mr. Jackson. I don't have any other
 18 questions. The attorney for the defendants might.
 19 MS. WEIL: Yeah. Can we take five minutes off
 20 the record?
 21 MR. MARKO: M-hm.
 22 THE VIDEOGRAPHER: Going off the record at
 23 5:38 p.m.
 24 (Recess taken at 5:38 p.m.)
 25 (Back on the record at 5:44 p.m.)

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1 THE VIDEOGRAPHER: We're back on the record at
 2 5:44 p.m.
 3 MS. WEIL: Good afternoon, Dr. Webber. And
 4 I'll try not to take too much of your time because I
 5 know you have a commitment.
 6 I think we introduced ourselves before, but my
 7 name is Rachel Weil, and along with my colleagues at
 8 Bowman & Brooke, I represent the defendants in the case
 9 CHX Texas and Dr. Papendick. Do you understand that?
 10 **THE WITNESS: Yes.**
 11 CROSS-EXAMINATION BY MS. WEIL:
 12 Q. Dr. Webber, do you live in Detroit?
 13 **A. No, I do not.**
 14 Q. Where do you live?
 15 **A. I live in Northville.**
 16 Q. Okay. And how far is that from downtown Detroit?
 17 **A. I think 35 minutes, roughly, by car.**
 18 Q. And so you're within about how many miles of downtown
 19 Detroit?
 20 **A. I'm not sure. Maybe somewhere between 30 and 34,**
 21 **probably.**
 22 Q. Okay. And are you available to testify in person at the
 23 trial of this case?
 24 **A. Probably not.**
 25 Q. And why not?

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1 **A. I have many commitments as far as surgery is concerned.**
 2 Q. Okay. So, you're just a really busy doctor and it would
 3 be hard for you to break away to testify in court; is
 4 that right?
 5 **A. Extremely busy. Yes.**
 6 Q. Okay. And that's -- but you're within 35 miles or so of
 7 the courthouse; am I correct?
 8 **A. That is correct.**
 9 Q. Okay. Dr. Webber, did you ever treat or see Mr. Jackson
 10 when he was incarcerated in the Michigan Department of
 11 Corrections?
 12 **A. I did not.**
 13 Q. Okay. So, you never saw him before May 31st of 2019
 14 when he was in your office; is that right?
 15 **A. That is correct.**
 16 Q. Okay. Did you review any of the records from the time
 17 that Mr. Jackson was incarcerated in the Missouri DOC?
 18 **A. I think I had --**
 19 Q. Excuse me. Michigan DOC.
 20 **A. Sure. I don't believe that I actually reviewed any**
 21 **records from the DOC; although, I had probably reviewed**
 22 **the operative report of Dr. Kansakar when I believe**
 23 **Mr. Jackson had his surgery at Lake Huron Medical Center**
 24 **in Port Huron.**
 25 Q. In 2016; is that right?

1 **A. Yes. Yes.**
 2 Q. Okay. Did you review any of the records or
 3 communications that involve Dr. Papendick?
 4 **A. No, I did not.**
 5 Q. Okay. So, you don't have any idea what Dr. Papendick
 6 did or considered before he decided to approve
 7 continuing care of Mr. Jackson's colostomy rather than a
 8 reversal surgery; is --
 9 MR. MARKO: Objection.
 10 Q. -- that a correct statement?
 11 MR. MARKO: Objection. Form and foundation.
 12 **A. Other than the segments that were played, no.**
 13 Q. Okay. So, you -- let me just go back and make sure --
 14 **A. Okay.**
 15 Q. -- we're clear on the record. You did not review
 16 anything that Dr. Papendick reviewed before he made his
 17 decision; is that correct?
 18 **A. That is correct.**
 19 MR. MARKO: Object. Same objection.
 20 MS. WEIL: Okay. What's the nature of the
 21 objection?
 22 MR. MARKO: It's form and foundation.
 23 BY MS. WEIL:
 24 Q. Did you review anything that Dr. Papendick -- any record
 25 that Dr. Papendick created?

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1 **A. Record, meaning something put into the EMR or paper?**
 2 Q. Any sort of record, any sort of medical record or any --
 3 **A. No.**
 4 Q. -- record of any communication.
 5 **A. No.**
 6 Q. Okay. Do you have any idea what Dr. Papendick
 7 considered when he was making his decision?
 8 **A. I do not.**
 9 Q. Do you have any idea of anyone Dr. Papendick spoke to
 10 when he was making his decision?
 11 **A. No, I do not know.**
 12 Q. Okay. Now, you went through a whole list of horrific
 13 problems that can befall someone that are risks to
 14 someone who has a surgery two years later rather than
 15 two years earlier; is that a fair statement? In other
 16 words, let me say that a different way.
 17 **A. Yes.**
 18 Q. You talked about a lot of things that were risks to
 19 Mr. Jackson because he waited until 2019 to have his
 20 colostomy reversed instead of having it reversed in
 21 2017; is that fair?
 22 **A. Yes.**
 23 Q. Okay. So, let's talk about some of those. You talked
 24 about prolapse?
 25 **A. Yes.**

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1 Q. And once again, prolapse is when more of the intestine
 2 comes out of the body; is that right?
 3 **A. That is correct.**
 4 Q. Okay. Did Mr. Jackson have prolapse?
 5 **A. I don't believe so.**
 6 Q. Okay. You talked about a parastomal hernia, I think; is
 7 that right?
 8 **A. Yes.**
 9 Q. And that was when the opening widens; is that right?
 10 **A. The fascial opening. Yes.**
 11 Q. Okay. That's right.
 12 **A. It becomes larger --**
 13 Q. Yeah. Because there's lots of openings, right?
 14 **A. Yes.**
 15 Q. Yeah.
 16 **A. It becomes larger than the actual colostomy diameter**
 17 **itself or colon diameter itself.**
 18 Q. Okay. That's called, again, a parastomal hernia?
 19 **A. Parastomal hernia.**
 20 Q. Okay. Parastomal...
 21 **A. Yes.**
 22 Q. Parastomal.
 23 **A. Parastomal hernia.**
 24 Q. Parastomal. Around the stoma, parastomal.
 25 **A. That's correct.**

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1 Q. Got it. Did Mr. Jackson have a parastomal hernia?
 2 **A. I don't remember if he did or not, but I'm sure he did**
 3 **to some extent because almost everybody has it. Almost**
 4 **everybody has it.**
 5 Q. Is it anywhere in your records that you diagnosed
 6 Mr. Jackson with a parastomal hernia?
 7 **A. No, it is not. But I wouldn't necessarily even included**
 8 **it in my records.**
 9 Q. Okay. Why not?
 10 **A. Because they're almost uniform so I often don't put it**
 11 **in there unless it's significant.**
 12 Q. So, it's not significant to have a parastomal hernia?
 13 **A. It is significant, but his may not have had any bowel in**
 14 **it so I would not have listed it.**
 15 Q. Okay. So if he had one, it was not significant; is
 16 that --
 17 **A. Right. Meaning the fascial opening is always going to**
 18 **be bigger than the actual colon diameter that's going**
 19 **through the fascia.**
 20 **But he didn't have any complications, per se,**
 21 **at that time of the parastomal herniation so I did not**
 22 **include that. But more than likely, yes, he did have**
 23 **it.**
 24 Q. Okay. Now, you said that another possible complication
 25 if someone waited longer to have a colostomy reversal

1 was colostomy stenosis. Did I remember that right or --
 2 **A. That's correct.**
 3 Q. -- write it down?
 4 **A. Correct.**
 5 Q. What is that?
 6 **A. That's where the colon becomes recessed.**
 7 Q. Okay.
 8 **A. And once it becomes recessed, the skin starts to close**
 9 **over the actual opening, you might say, and it becomes a**
 10 **stenotic or narrowed opening. Stenosis means narrowing.**
 11 Q. Okay. And so instead of the -- maybe is it the reverse
 12 of the first one we talked about, the prolapse? Instead
 13 of the intestine being out too far, it's in too far; is
 14 that a fair lay way to put it?
 15 **A. That's a -- I guess an okay way to put it from a**
 16 **layman's perspective. Sure.**
 17 Q. Okay. Did Mr. Jackson have a colostomy stenosis?
 18 **A. No, he did not.**
 19 Q. Okay. You talked about the risk of large bowel
 20 obstructions, and you talked about that -- those being
 21 very serious; is that right?
 22 **A. They are surgical emergencies.**
 23 Q. Okay.
 24 **A. A large bowel obstruction is considered a surgical**
 25 **emergency.**

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1 Q. Did Mr. Jackson have a large bowel obstruction?
 2 **A. No, he did not.**
 3 Q. Okay. You talked about contact dermatitis. What is
 4 that?
 5 **A. That's where the colostomy appliance is attached to the**
 6 **skin, and there's a reaction to the, you might say,**
 7 **adhesive that is applied to the skin to get the bag**
 8 **to -- or to get the colostomy appliance to stick. Or it**
 9 **can be caused by the actual deposition of stool onto the**
 10 **skin.**
 11 Q. Okay. Did Mr. Jackson have contact dermatitis?
 12 **A. I can't remember.**
 13 Q. Okay. And it's not in your records anywhere that --
 14 **A. No.**
 15 Q. -- there was contact dermatitis?
 16 **A. Right. But I -- again, I wouldn't have put something**
 17 **like that in my record most likely.**
 18 Q. Okay. You also talked about skin excoriation which I
 19 think kind of follows onto the contact dermatitis --
 20 **A. Right.**
 21 Q. -- is that right?
 22 **A. Yes.**
 23 Q. What is skin excoriation?
 24 **A. Again, the skin becomes irritated by the -- either the**
 25 **appliance adhesive or stool leaking out around the**

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1 appliance. And there's some, you might say, sloughing
2 of the skin or redness or reaction around the area where
3 the appliance is applied. And almost all patients have
4 that to some extent.

5 Q. Okay. But there's nothing in the record to suggest that
6 Mr. Jackson had skin excoriation; is that right?

7 A. No. There's nothing in the record, but I'm sure he had
8 some element of it.

9 Q. Okay. Now, I also -- I have some other -- I found some
10 other things that can happen --

11 A. Sure.

12 Q. -- that are risks of -- risks to people who have
13 colostomies.

14 A. Okay.

15 Q. So, I want to ask you about a few of those. What is
16 stoma necrosis?

17 A. So, that stoma necrosis wasn't a risk for Mr. Jackson
18 because stoma necrosis is when we place the appliances
19 on the patient during the surgery, you have to -- you
20 know, the colon is a living, viable structure and has a
21 blood supply to it that's external to the actual lumen
22 of the colon.

23 If you think about the colon as a cylinder,
24 and the functioning part of that cylinder is the inside
25 of this bottle, you might say, and the stool comes

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1 through that passage, external to that is going to be
2 what we call the mesentery of the colon, the blood
3 supply to the colon, the lymphatic drainage of the
4 colon. And that part has to be -- the hole has to be
5 wide enough to get that part of it through either --
6 also. And if there's any interruption or tightness to
7 that fatty tissue that's attached to the colon, the
8 mesentery of the colon, then it can cause a lack of
9 blood supply to the colon and result in stoma necrosis.

10 That is something that occurs in the immediate
11 aftermath, usually within a few days of the actual
12 creation of a colostomy, and would -- he would not be at
13 risk for that.

14 Q. Okay. And there's no indication that -- anywhere in the
15 records that you've seen that he ever had it; is that
16 right?

17 A. That's correct.

18 Q. Okay. Is bleeding a risk to someone who has a
19 colostomy?

20 A. Bleeding from the excoriation around the skin or
21 bleeding from the actual colostomy itself?

22 Q. I guess either or both.

23 A. So, bleeding from a colostomy can be from a multiplicity
24 of factors. It can be from GI bleeding from the upper
25 GI tract, meaning a bleeding peptic ulcer from the

1 stomach. It can drain through the entire intestinal
2 tract and come out as blood in a colostomy.

3 It can actually be from proximal, meaning
4 upstream colon pathology, such as diverticulosis, or
5 somebody who might have what we call inflammatory bowel
6 disease such as Crohn's colitis or ulcerative colitis.
7 Those autoimmune inflammatory bowel diseases are known
8 to cause bleeding, so forth and so on.

9 And then bleeding can occur because
10 colostomies -- or, again, you know, stomas that are
11 sticking or protruding out of the abdomen, and for any
12 number of reason, they can bleed from just the mucosa.
13 Because, again, the mucosa, the pink part that you see
14 sticking out, is not meant to be sticking outside of
15 anybody's body, and so just any form of irritation can
16 cause that mucosa to bleed.

17 Q. Is there any indication in the records that Mr. Jackson
18 had bleeding from his stoma at any point?

19 A. I don't know --

20 Q. Okay.

21 A. -- is the answer.

22 Q. And not during the time that you saw him or treated --

23 A. Right.

24 Q. -- him; is that right?

25 Okay. Is abscess a risk of a -- for a patient

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1 with a stoma?

2 A. Again, an abscess related to a stoma is usually a very
3 near term complication of an immediate stomal surgery.
4 So, I don't believe that Mr. Jackson was at risk for
5 that.

6 Q. Okay. Now, when you saw Mr. Jackson in June -- well,
7 the first time you saw him was the end of May in 2019.
8 Was his -- his colostomy was functioning well, was it
9 not?

10 A. I can't remember whether it was functioning well or not,
11 to be honest. It was functional.

12 Q. Okay. And you didn't --

13 A. So, I'm --

14 Q. I'm sorry. Go ahead.

15 A. I'm not going to qualify it by saying it was functioning
16 well or not because I don't remember.

17 Q. Okay, but you didn't put anything in your records to
18 suggest that it was not functioning well, did you?

19 A. That's correct.

20 Q. Okay.

21 A. Yeah. It was functioning, and I will stand by that.

22 Q. Okay. And he was not having any of this list of
23 problems that we just went through; is that right?

24 A. Right. But, again, these are potential complications
25 that could occur.

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1 Q. Right, but he did not have any of them; is that right?

2 **A. That is correct.**

3 Q. Okay. And you did not make any notation in your record

4 of any other problem that Mr. Jackson was having with

5 his colostomy in May or June of 2019; is that a fair

6 statement?

7 **A. I would again say it's a fair statement, but, again,**

8 **there is psychological and emotional harm caused by a**

9 **colostomy. And I am not going to make a record of that**

10 **in my EMR or electronic medical record, but there is**

11 **invariably some emotional harm and psychological harm**

12 **caused by the creation of a colostomy.**

13 Q. Doctor, you talked about the fact that -- I think you

14 called it ruptured diverticulitis, that Mr. Jackson had

15 the colostomy in the first place because he had a

16 fistula that --

17 **A. Correct.**

18 Q. -- developed because of his diverticulitis; is that

19 right?

20 **A. That's correct. Yes.**

21 Q. And that was causing feces to leak places where they

22 were not supposed to be, like into his --

23 **A. I believe one of --**

24 Q. -- I think his bladder, right?

25 **A. Yeah. I think one of his issues was a leakage or an**

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1 **abnormal communication between the colon and his**

2 **bladder.**

3 Q. Okay. And that's dangerous, right?

4 **A. It can be.**

5 Q. Okay. And then, I mean, it can be life-threatening,

6 can't it?

7 **A. It can be.**

8 Q. Okay. So, the colostomy at the time that Mr. Jackson

9 got the colostomy was a good thing, right?

10 **A. It was medically necessary.**

11 Q. It was medically necessary, and potentially saved his

12 life, right?

13 **A. And potentially life-saving, I would agree with that.**

14 Q. Okay. Doctor, do you have any knowledge of whether --

15 strike that.

16 We looked at -- or counsel showed you a

17 notation in Dr. Kansakar's record at the time that she

18 was about to perform Mr. Jackson's colostomy; is that

19 right?

20 **A. Yes.**

21 Q. And she was talking about contemplating a reversal in

22 the near term; is that right?

23 **A. Sometime in the future. Yeah.**

24 Q. Do you have any knowledge whether Dr. Kansakar was

25 consulted later by anyone from the Missouri Department

1 of Corrections about whether colostomy reversal for

2 Mr. Jackson was medically necessary?

3 **A. Did you say Missouri Department of Corrections?**

4 Q. I probably did, but I meant Michigan.

5 **A. Okay.**

6 Q. Thank you. I don't know why --

7 **A. I used to live in Missouri so I was kind of shocked**

8 **about that.**

9 Q. No. Let's try that again.

10 **A. Okay.**

11 Q. Do you have any knowledge of whether Dr. Kansakar was

12 ever consulted by anyone from the Michigan Department of

13 Corrections later, after Mr. Jackson had his colostomy,

14 about whether it was medically necessary to reverse the

15 colostomy?

16 MR. MARKO: Objection. Foundation and

17 hearsay.

18 **A. I don't know.**

19 Q. Okay. Doctor, colostomy reversals have risks, too,

20 don't they?

21 **A. Yes. Any surgery has risks.**

22 Q. Okay. I'm gonna show you something.

23 **A. Sure.**

24 Q. And we haven't figured out. This is a defense exhibit

25 and --

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1 **A. Okay.**

2 Q. -- we will figure out exactly how to mark it, but...

3 DEFENSE EXHIBIT H

4 Surgical Documents (6 pages)

5 WAS MARKED FOR IDENTIFICATION

6 MR. MARKO: Well, hold on. I'd like to see a

7 copy.

8 MS. WEIL: I have a copy for you.

9 MR. MARKO: Okay.

10 MS. WEIL: Do you need copies for anybody

11 else?

12 MR. MARKO: No, no.

13 BY MS. WEIL:

14 Q. Doctor, what I have handed to you I will represent is a

15 portion of your record. It is page 573 of 579 is what

16 it says on the bottom. I don't see a litigation

17 Bates number on it, but I see page 573 of 579 is the

18 first page. And I just want to direct your attention to

19 the third page which is page 575 of 579.

20 **A. Okay.**

21 Q. Okay? And I'm in the paragraph that says indications

22 for procedure. Do you see that?

23 **A. Yes. Yes, I do. M-hm.**

24 Q. And about two-thirds of the way-ish down, there's a

25 sentence that starts, "Informed consent was obtained and

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1 secured in the chart." Do you see that?

2 **A. Yes, I do.**

3 Q. Okay. And after that, I want to read you something.

4 And you can tell me if I read it correctly.

5 It says, "after patient was made aware of all

6 risks and benefits of the procedure including but not

7 limited to the risk of heart attack, stroke, death,

8 infection, the potential need for reoperation, and the

9 potential for a leak or potential for damage to

10 surrounding structures including the ureter and

11 genitourinary system, the patient signed informed

12 consent after a lengthy discussion."

13 Did I read that correctly?

14 **A. That is correct.**

15 Q. Okay. And those are all serious risks that were

16 involved -- that were -- this surgery carried all of

17 those serious risks; is that true?

18 **A. Yes.**

19 Q. Okay. And do you remember anything about the lengthy

20 discussion you had with Mr. Jackson?

21 **A. Again, I have these discussions with all my patients,**

22 **so --**

23 Q. Okay.

24 **A. -- I don't remember the specifics.**

25 Q. Okay.

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1 **A. But this sounds like something we would discuss.**

2 **Absolutely.**

3 Q. And do you have any specific recollection of any -- of

4 anymore that you would have discussed?

5 **A. Not really, other than what's already, you know, I guess**

6 **memorialized in this dictation.**

7 MS. WEIL: Okay. I have no further questions

8 subject to anything else that Mr. Marko may ask you.

9 **THE WITNESS: Sure.**

10 MR. MARKO: Tell me when you guys are ready.

11 THE VIDEOGRAPHER: We're all set, John. It's

12 all set, John.

13 MR. MARKO: Ready? Oh, I'm sorry.

14 REDIRECT EXAMINATION BY MR. MARKO:

15 Q. Okay. Doctor, let's go over. So, you were asked about

16 what Dr. Papendick did or didn't do. Do you have any

17 idea what Dr. Papendick did or didn't do?

18 **A. No.**

19 Q. If Dr. Papendick testifies to this jury consistent with

20 his deposition testimony on page 10 that he made

21 decisions regarding the approval or otherwise of this

22 colostomy reversal procedure, and that in doing so, he

23 did not meet with or talk to the patient, do you think

24 that's appropriate?

25 MS. WEIL: Objection. Leading and foundation

1 and assumes facts not in evidence.

2 **A. Yeah. Unfortunately, I don't think it's appropriate,**

3 **but again, I think people that make these decisions**

4 **never meet with their patients. They sit in --**

5 MS. WEIL: I move to -- I'm sorry.

6 **A. -- some kind of...**

7 MS. WEIL: I'm sorry. I'm sorry. I thought

8 you were finished.

9 MR. MARKO: Yeah. Please don't interrupt the

10 doctor.

11 MS. WEIL: I'm sorry. I thought he was

12 finished. I apologized.

13 **A. I think it's kind of a sterilized procedure where**

14 **patients -- or doctors like Dr. Papendick sit in**

15 **boardrooms and make decisions on cost cutting and**

16 **whatever based on, you might say, administrative orders**

17 **from whom he works.**

18 Q. Would you ever make a decision --

19 MS. WEIL: I'm sorry. I never got to object

20 because you didn't let me -- you didn't let me object

21 after he was finished.

22 I'm going to object and move to strike the

23 whole answer as speculation, as lacking foundation, as

24 irrelevant, and as 401, 403.

25 MR. MARKO: Are you done?

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1 MS. WEIL: I am done.

2 BY MR. MARKO:

3 Q. Okay. Now, would you ever make a medical decision

4 affecting the future of one of your patients without

5 ever seeing or talking to the patient?

6 MS. WEIL: Objection. Argumentative.

7 **A. Again, I'm a front-line clinician or physician, surgeon,**

8 **whatever you want to say. I talk to my patients,**

9 **period. I don't think I would ever offer a patient**

10 **surgery without sitting down and talking to them**

11 **face-to-face or even by Zoom and, you know,**

12 **telemedicine --**

13 Q. Yeah.

14 **A. -- and telling them, you know, the potentials, risks of**

15 **any surgery, and the reason why we're doing the surgery,**

16 **and allowing and affording the patient the opportunity**

17 **to ask the questions that they want to ask so that all**

18 **of their questions are answered to their satisfactions.**

19 Q. You were asked questions about Dr. Kansakar who you said

20 you know. If Dr. Kansakar testifies to this jury that

21 in her professional medical opinion that Mr. Jackson's

22 reversal surgery was medically necessary, do you agree

23 with that opinion?

24 MS. WEIL: Objection. Foundation, leading,

25 assumes facts not in evidence.

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MR. MARKO: Well, she already did testify to that, and it's under -- I mean when you --

MS. WEIL: Well, we don't know that.

MR. MARKO: -- say these things -- what do you mean, we --

MS. WEIL: But we don't --

MR. MARKO: -- don't know that?

MS. WEIL: -- know that. I mean, she's -- okay.

MR. MARKO: We do know that.

MS. WEIL: The objection's on the record.

MR. MARKO: We do know that. We know it as a fact because she's already testified under oath and it's gonna be played to the jury.

MS. WEIL: Well --

MR. MARKO: So we know that. So when you say those things, it's just very disingenuous because we know it. We all know it. Me and you know it. They know it. Everybody knows it. The jury's gonna know it.

BY MR. MARKO:

Q. Okay. So, I want you to assume that Dr. Kansakar will testify that Mr. Jackson's reversal surgery was medically necessary in her professional opinion. Do you agree with that opinion?

A. I agree with it, but I also have my own opinion which

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I've already stated for the record that I believe the surgery was medically necessary.

Q. Doctor, you were asked questions about risks of a surgery. Is there risk in everything, in any surgery anywhere?

A. There is a risk in living, period. I mean, you can -- one of us can walk out today and get hit by a car or get in a car accident on the way home. There is a risk to any surgery.

The fact that we discussed these risks with the patient and memorialized them in this dictation is important because it tells the record that we discussed the risks with the patient, that we didn't just whisk the patient off to surgery without having an in-depth conversation with the patient.

And because -- I mean just because there are risks to any surgery or to this surgery in particular does not contraindicate the surgery itself; meaning, there are patients who we remove cancers from who -- there are immense risks of the surgery, but yet, the patient should have the surgery despite the risks. And the options may be prohibitive in some instances, but the options are limited for the patient.

And so we have a conversation with these patients and tell them there are risks, but I will tell

you, there is absolutely no way that you're gonna tell

me that these risks that we specifically enumerated to

Mr. Jackson would in any way be considered

contraindications to proceeding with the surgery;

otherwise, none of us would have surgery for anything.

Like I said -- or I will tell you, yesterday,

I removed a 28-centimeter kidney cancer from a patient

yesterday with enormous risks to the patient, and

included fixing a large incisional hernia. And I told

the patient this is an eight-hour operation and there is

a chance that you may die from this operation from

hemorrhage. And he accepts the risks, and we enumerate

these risks in the dictations.

But I think it's very disingenuous to say that

these operations have a risk and say that risks of

surgery contraindicate any form of surgery and that we

should deny surgeries to patients because they

inherently have a risk. Every surgery, albeit small, I

mean, even a small surgery, has a risk. The risk --

there is just a risk of going under anesthesia, whether

it's local anesthesia or general anesthesia even without

making a cut on a patient.

Every patient is subjected to risk, and that's

why we do risk stratification, but we don't stop doing

surgery on patients unless the risks are so prohibitive.

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We do what's called a risk-benefit analysis to any surgery.

And we say to the patient, "Listen, here is the benefit of doing this surgery versus the risk."

The risk here of these complications in the hands of an experienced, board-certified surgeon such as myself are minimal, minimal, and certainly do not contraindicate not performing the surgery.

I tell him these things because there are things that can happen anatomically or things that can happen in any surgery that might cause one of these unfortunate complications to occur, but we try to, you might say, mitigate against these risks and we operate very carefully and judiciously and prudently. I'm not a surgeon that works hard or fast. I am a surgeon who is meticulous about what I do. I respect the tissues. And this is what I did when I did the surgery with Mr. Jackson.

And although these risks are stated for the record, these risks should not be considered a reason for denying any patient this kind of surgery.

Q. Thank you, Doctor.

MS. WEIL: I'm gonna move to strike that as nonresponsive after the first sentence because the only question was whether there risks in every surgery. I'm

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1 gonna move to strike --

2 MR. MARKO: Well, I think it --

3 MS. WEIL: -- the entire rest of the speech as

4 unresponsive.

5 MR. MARKO: I think it was very responsive,

6 and rather than ask each individual question and waste

7 everybody's time, I think he was explaining his answer

8 and was responsive.

9 Doctor, thank you so much. I don't have any

10 other questions.

11 MS. WEIL: Thank you, Doctor. I don't either.

12 **THE WITNESS: All right. Thank you.**

13 THE VIDEOGRAPHER: This concludes the

14 deposition. We're going off the record at 6:08 p.m.

15 (Video recording ended at 6:08 p.m.)

16 MR. MARKO: Okay. Just for the deposition

17 transcript, I'd like to stay on the record real quick.

18 So, I heard you ask the doctor questions about

19 his distance from the courthouse. We noticed this as a

20 video deposition due to his unavailability. There was

21 no objection from the defendants. This was noticed as a

22 trial deposition. Now, you haven't said this. You

23 certainly haven't said this before today.

24 This has been noticed for how long guys?

25 Weeks?

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1 MR. LUMBARD: Weeks.

2 MR. CROSS: Yeah, weeks.

3 MR. MARKO: I think two weeks, I think, we

4 noticed it for. So, I hope that you'll follow the rules

5 and that you're not gonna now, after this doctor has

6 taken time out, attempt to disrespect his schedule and

7 all of us and the costs that we have by doing a

8 after-the-fact objection to his testimony when we all

9 knew, and you were told, that this was going to be a

10 trial dep due to his unavailability.

11 MS. WEIL: Okay. I'm not going to -- this

12 should not be on the record, and I move to strike all of

13 that from the record because it has nothing to do with

14 anything, and it doesn't belong on the record.

15 But, nevertheless, we will all see what

16 happens procedurally as it plays out, and that's all I'm

17 going to say. We all need to comply with the rules, and

18 we will do it, and you will do it as well.

19 MR. MARKO: Yeah. I just don't want any

20 trickery because that's what I'm getting.

21 MS. WEIL: Can we please go off the record?

22 MR. MARKO: Sure.

23 (Deposition concluded at 6:10 p.m.)

24 ///

25 ///

1 DEPOSITION WEBBER EXHIBIT NO. 1

2 Deposition Notes (2 pages)

3 WAS MARKED FOR IDENTIFICATION

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1 CERTIFICATE OF NOTARY

2

3 STATE OF MICHIGAN)

4) SS

5 COUNTY OF OAKLAND)

6 I, Jennifer Wilke, Certified Shorthand Reporter, a

7 Notary Public in and for the above county and state, do

8 hereby certify that the above deposition was taken

9 before me at the time and place hereinbefore set forth;

10 that the witness, JOHN WEBBER, M.D., was by me first

11 duly sworn to testify to the truth, and nothing but the

12 truth; that the foregoing questions asked and answers

13 made by the witness were duly recorded by me

14 stenographically and reduced to computer transcription;

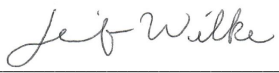
15 that this is a true, full and correct transcript of my

16 stenographic notes so taken; and that I am not related

17 to, nor of counsel to either party nor interested in the

18 event of this cause.

19

20 

21

22 Jennifer Wilke, CSR-8575

23 Notary Public,

24 Oakland County, Michigan

25 My Commission expires: October 4, 2030

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